2022 Health Benefit Plan Filing Guidance

Webinar: May 3, 2021 9:00 am Pacific

April 26, 2021

Filing Submission Deadlines

	Rates	Forms	Binders
All individual Medical plans	June 2nd	June 2nd	June 2nd
All small group Medical plans	July 14th	July 14th	July 14th
All exchange-certified dental plans	June 2nd	June 2nd	June 2nd

* These deadlines are applicable to Rate, Form, Binder and Network Adequacy submission

- Rate Filing Requirements -

NV Rate Review Process

- All health benefit plan rate filings will be reviewed by consulting actuaries and/or DOI staff.
  - Carriers to pay for cost of external reviewing actuaries (NRS 686B.112)

COVID-19

- Detailed breakdown and quantitative and qualitative support for:
  - Morbidity
  - Unit Cost & Utilization
  - Other
- Either option is acceptable
  - 2020 experience with adjustments
  - 2019 trending forward with adjustments
- Detailed quantitative and qualitive support for any adjustments

Basis for 2022 Rate Filings - I

- The Affordable Care Act (ACA), including federal regulatory and sub-regulatory guidance in effect on the filing submission due date.
- Nevada State law.
- Other state guidance, e.g., this slide deck.
- If, before rates are finalized, there is a change in the federal or state law/guidance affecting rates, carriers may be allowed to refile rates.
  - COVID-19 adjustment
  - Risk adjustment transfer payments

Basis for 2022 Rate Filings - II

- Actuarial Value (AV) Calculator for 2022
- Final Notice of Benefit and Payment Parameters for 2022
- 2022 Unified Rate Review Template (URRT) and instructions
- Updated Nevada rate filing template and instructions
  - Version 4.0 or later, as posted on the Division's website.

Detailed Rate Review Timeline

- The dates on the following slide are approximate based on the expected delivery date of the initial objection letter and maximum turnaround times.
  - For example, if an objection letter is sent 2 days early, the response is due 2 days earlier than the current schedule and all of the subsequent deadlines are changed accordingly.
- The final timeline will be posted on our website.

Detailed Rate Review Timeline - Draft

Description	Responsibility	Individual Plans	Small Group Plans
Rate Filing Due	Carriers	6/2/2021	7/14/2021
First Objection to Carriers	Division	6/16/2021	7/28/2021
Response to First Objection	Carriers	6/25/2021	8/4/2021
Second Objection to Carriers	Division	7/2/2021	8/11/2021
Response to Second Objection	Carriers	7/12/2021	8/25/2021
Third Objection to Carriers	Division	7/19/2021	9/2/2021
Response to Third Objection	Carriers	7/26/2021	9/8/2021
Proposed Rate Changes posted on Division's website	Division	8/1/2021	8/1/2021
Final Rate Decisions to Carriers	Division	8/18/2021	9/16/2021
Final Rate Modifications to DOI	Carriers	8/24/2021	9/24/2021
Final Data Transfer to SSHIX	Division	8/25/2021	NA
Final Approved rates posted on the Division's website	Division	10/1/2021	10/1/2021

Confidentiality of Information Filed

- State law requires the Division to hold the URRT and the actuarial memorandum confidential.
- For information that is not required to be kept confidential under state law and that you believe to be proprietary, submit a written request for it to receive confidential treatment pursuant to NRS 679B.190(5)(b). We recommend that you:
  - Include the request in the cover letter for the filing,
  - Include the request in a “Note to Reviewer” in SERFF, and
  - Indicate “proprietary and confidential” directly on each document subject to the request, regardless of the file format (excel, PDF, word, etc.).

Division of Insurance Website - Rates

- Proposed 2022 rates will not be posted
- Proposed rate filing information (min, max, average rate changes) will be posted on August 1st
- Approved 2022 individual and small group rates will be posted by October 1st
- Updated small group quarterly rates will not be posted on the Division's website
- Information from plan & benefits and service area templates will be posted on the website, so please complete correctly

Rate Submission Requirements

- Separate filings for rates and forms
  - Health benefit plans
- All documents must be submitted in SERFF
- Follow standardized naming convention for templates

Standardized Naming Convention

- CarrierName_YYYYQ#mkt_v#_Template.xml
  - CarrierName: Up to 6 Characters which identify the carrier
  - YYYY: four digit filing year
  - Q#: “Q” followed by the quarter number, “1” for annual and “3” for small group quarterly filings
  - mkt: “i” for individual “s” for small group filings
  - v#: v followed by the version number (increment for each update to the filing)
  - Template: indicate one of the following: NVT, RT, URRT, PBT, SAT
    - NVT – Nevada Rate Filing Template
    - RT – Federal Rates Template
    - URRT - URR Template
    - PBT - Plan and Benefit Template
    - SAT - Service Area Template

SERFF Submissions - I

- Rate/Rule Tab of SERFF (public access)
  - Rate Data Template (XLS and XML formats)
  - Consumer Disclosure – Part II
    - Required for **all** submissions
  - Actuarial Memorandum – Part III (redacted)
    - Public version - any information that is a trade secret or confidential commercial/financial information should be redacted

Redacted Actuarial Memorandum

- Federal guideline: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions_for_the_Redacted_Actuarial_Memorandum_20150416.pdf
  - Carriers can redact any information that is a trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations at 45 CFR § 5.65.
  - Carriers must not redact information unless its release would likely result in specific, reasonably foreseeable, and substantial competitive harm.
    - Be prepared to explain how each redacted item meets the federal criteria for redaction.

SERFF Submissions - II

- Supporting Documents tab of SERFF
  - 2022 Unified Rate Review Template (URRT) - Part I (confidential)
    - both XLS and XML formats
  - Actuarial Memorandum - Part III, (confidential)
    - Format must follow the order of the 2022 URR instructions
  - Exhibits supporting the Actuarial Memorandum (in Excel format, with working formulas)

Actuarial Memorandum

- Is an actuarial communication subject to Actuarial Standard of Practice (ASOP) No. 41
  - Provide sufficient detail so that a qualified health actuary would be able to evaluate the submission.
- Provide quantitative support
- Provide narrative descriptions
  - The methodology, data source, assumptions, justification, etc., for all adjustments need to be clearly communicated

SERFF Submissions - III

- Supporting Documents tab of SERFF
  - Plan & benefits template
    - Both XLS and XML formats
  - Service area template
    - Both XLS and XML formats
  - 2022 Nevada rate filing template (version 4.0)
    - Both XLS and XML formats
  - AV Calculator screenshots and support for unique plan designs
  - Documentation for $ limit substitutions
  - Completed rate filing checklist

Formula for Timely Approvals - I

- Follow 2022 federal and state guidance
  - COVID-19 documentation
- Submit complete, well-documented filings:
  - URRT
  - Actuarial memorandum: Detailed description of methods and assumptions, including changes since prior year, with supporting exhibits
    - Format in order of URR instructions, with same headings
    - Provide sufficient detail in narrative and numerical demonstrations so that another qualified actuary could evaluate the submission (per ASOP No. 41) – see checklist
    - Provide all supporting exhibits in Excel with working formulas
  - NV rate Filing Template (v 4.0 or later) completed in accordance with instructions

Formula for Timely Approvals - II

- Ensure that issues raised in prior year's objection letters are addressed in current filing
- Prior to submission, review for consistency, all information in the rate, form and binder filings for the single risk pool
- Once review starts, any changes to the forms and/or binders must be coordinated with the rate filing and vice versa.
- Any questions, contact the DOI

Common Areas of Objections

- Rate increase calculation, components of rate increase
- One or more of the following items were not fully supported or justified
  - Trend development, other projection factors not fully supported
  - Manual rate development not fully supported or justified
  - Plan level adjustments
  - Geographic factor development
  - Risk adjustment transfer payment development

Example: Calculating the Threshold Rate Increase

Plan	Current Annual Premium	Annual Premium Based on Proposed Rates	Rate Change
A	$10,000,000	$11,000,000	10.00%
B	$20,000,000	$19,000,000	-5.00%
C	$15,000,000	$18,000,000	20.00%
D	$ 5,000,000	$ 5,000,000	0.00%
Total	$50,000,000	$53,000,000	6.00%

Weighted average rate change: ($53M/$50M)-1 = 6.00%

Risk Adjustment

- Clearly document the methodology, data, assumptions used to determine the estimated adjustment to the index rate
- Reflect any planned changes to the risk adjustment program
  - Risk adjustment fees should be reported as a non-benefit expense, not netted against the risk adjustment transfer payment.

NV RATEE Program

- Pilot program starting from this year
- Similar to CMS report, but release earlier
- 05/01/2021 RATEE file from carrier
- Deadline: First Friday of May
- Confidentiality
- Comments are welcome

2022 Rating Parameters – No Change

- Age curve 3:1 federal default
- Geographic rating areas:
  1. Clark and Nye counties
  2. Washoe county
  3. Carson City, Lyon, Douglas and Storey counties
  4. All other counties
- Maximum tobacco rating factor allowed - 1.5
  - May vary by age
  - T21 Federal Regulation raised minimum age for sale of tobacco products to age 21
- Separate individual and small group risk pools

Impact of Tobacco 21 Legislation

- The Tobacco 21 legislation was enacted on December 20, 2019, effective immediately.
- Tobacco surcharges may only apply to legal tobacco users.
  - No tobacco surcharges are allowed under age 21

2022 Exchange Fee

- Exchange Fee - 3.05% of premium for QHPs and SADPs
  - Same as 2021

Actuarial Value – AV Calculator

- Actuarial support should include:
  - A description and explanation of any differences between results from the Plans & Benefits template and stand-alone AV calculator for unique plan designs
  - A description of any features not included in the AV calculator
  - Actuarial certification of AV calculator results

Actuarial Value - Unique Plan Design

- Actuarial support should include:
  - Reasons plan design incompatible with AV calculator
  - Design differences cited must be material
  - Identification of alternative method pursuant to:
    1. 45 CFR 156.135(b)(2) or
    2. 45 CFR 156.135(b)(3)
  - Standardized plan population data used
  - Description of data, assumptions and methods used
- May use the FFM's Unique Plan Design Supporting Documentation and Justification form

Small Group Issues

- Tobacco rating: applied separately, on a per-member basis
- Carriers cannot impose contribution or participation rules for small employers that apply for coverage between 11/15 and 12/15 of each year.
- Quarterly rate updates are allowed for **Q3 only**:
  - Standardized rate effective dates (January 1, April 1, July 1, October 1). Monthly trend adjustments are not allowed.
  - Q3 updates due March 15th
  - Plans may not be added with the 7/1 update

- Form and Binder Requirements -

2022 Filing Timeline for Individual Carriers

- All Individual QHP and Non-QHP binders must be submitted in SERFF no later than June 2nd , 2021
- All form and rate filings for individual carriers due June 2nd , 2021
- The NV DOI will provide final decision on August 25th , 2021

2022 Filing Timeline for Small Group Carriers

- All Small Group QHP and Non-QHP binders must be submitted in SERFF no later than July 14, 2021
- All form and rate filings for Small Group carriers due July 14, 2021
- The NV DOI will provide final decision on or before October 1st , 2021

Risk Pool Filings

- All products from the same risk pool must be submitted within a single form SERFF filing
- Benefit variability within a product will not be allowed
- Cost share variability within a plan will not be allowed
- Riders for non-EHBs allowed off Exchange

Binder Submissions

- Separate binders for individual and small group filings for each carrier
- Must include validated Plan Management templates
- Must include the completed MHPAEA Attestation Letter
- Must include the network adequacy supporting data and documentation
- Please follow the naming convention for templates

MHPAEA Attestation Letter

- Supporting Documentation in binder.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
Compliance Attestation

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Description	Reference	Carrier Comments	Attestation
Applicability of mental health parity	42 U.S.C. 18031(j)		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to applicability, and is in compliance with the applicable requirements.
Aggregate lifetime limits	42 U.S.C. 300gg-26 (a) (1), 45 CFR 146.136(b)		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the aggregate lifetime limits, and is in compliance with the applicable requirements.
Annual limits	42 U.S.C. 300gg-26 (a) (2), 45 CFR 146.136(b)		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the annual limits, and is in compliance with the applicable requirements.
Financial requirements and treatment limitations	42 U.S.C. 300gg-26(a) (3), 45 CFR 146.136(c), 45 CFR 146.136(d)(2)		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the financial requirements and treatment limitations, and is in compliance with the applicable requirements.
Availability of plan information	42 U.S.C. 300gg-26(a)(4)		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the availability of plan information, and is in compliance with the applicable requirements.
Internal claims and appeals and external review processes	45 CFR 147.136		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the internal claims and appeals and external review processes, and is in compliance with the applicable requirements.
Nonquantitative treatment limitations (NQTL)	42 U.S.C. 300gg-26(a) (3), 45 CFR 146.136 (c),45 CFR 156.115(a)(3), ACA FAQs Part 34		☐ The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the NQTL, and is in compliance with the applicable requirements.

Whether the mental health services are outsourced? _____ If the answer is "Yes", please provide more details _____

Name of Organization / Agency: _____
Street _____
City, State, Zip Code: _____
Phone: _____
Authorized Signature: _____
Print Name: _____
Title: _____
Date: _____

Template Naming Convention

- CarrierName_YYYYmkt_v#_Template.xml
  - CarrierName: Up to 6 Characters which identify the carrier
  - YYYY: four digit filing year
  - mkt: “i” for individual “s” for small group filings
  - v#: v followed by the version number (increment for each update to the filing)
  - Template: indicate one of the following: PBT, DT, NT,SAT,ECP, RT, BRT, URRT
    - PBT - Plan and Benefit Template
    - DT – Prescription Drug Template
    - NT – Network Template
    - SAT - Service Area Template
    - ECP - Essential Community Providers Template
    - RT – Federal Rates Template
    - BRT – Rating Business Rules Template
    - URRT - URR Template

Health Form Filings

- Redlined versions of SOBs and EOCs for existing plans
- AV calculator screen shots for each plan
- Upload completed checklist under the "Supporting Documentation" tab
  - http://doi.nv.gov/Insurers/Life_and_Health/ACA_Plans/Form_Filings_and_Plan_Certification/
- Please follow the naming convention for forms

Form Naming Convention

- PlanMarketingName_PlanID_Form_type_v#.pdf
  - PlanMarketingName: Please use acronyms and not the full name
  - Form: Cert, EOC, Pol, Sch, App
  - PlanID: Last 7 digits of HIOS Plan ID (use the product ID for documents that will be paired with multiple plans)
  - Type: “r” for redline version and “c” for clean copy
  - v#: version number

** example: StayHome4NVSilver1_0010001_r_v1.pdf*

Removing Plans From a Product

- Carriers may remove plans from a product each year
- All affected policyholders must receive a notice of renewal with altered terms pursuant to NRS 687B.420
  - Policyholders must be mapped to a plan within this product at the same metallic level (or nearest metallic level if no plan at the same level will be available)

2022 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2021)
- Plan includes embedded pediatric dental and vision consistent with NV CHIP and FEDVIP, respectively
- 45 CFR 156.115 prevents combined limits for rehabilitation and habilitation services
- Rehabilitation Services
  - 120 visits per year, no combined limit with Habilitation Services
- Habilitation Services
  - 120 visits per year, no combined limit with Rehabilitation Services

Documentation for $ limit substitutions

- ABA benefit limit
  - A maximum benefit of not less than the actuarial equivalent of $72K per year for ABA, justified by an actuary
  - Must specify the ABA benefit limits (or unlimited)
- Coverage for special food for PKU
  - Actuarial equivalent of $2,500 minimum

Plan Service Area

- QHP service areas must equal one or more rating territories
- Nevada's rating territories for 2022 are unchanged
- Off-exchange plan service areas may use partial counties
  - May be defined by a collection of Zip Codes

Prescription Drugs

- Health plans must cover at least the greater of: (1) one drug in every United States Pharmacopeia (USP) therapeutic category & class; or (2) the same number of drugs in each USP category & class as Nevada's benchmark plan
- Our benchmark is Solutions HMO Platinum 15/0/90%

Prescription Drugs

- Issuers have the flexibility to determine whether to include or exclude coupon amounts from the annual limitation on cost sharing, regardless of whether a generic equivalent is available.

Formulary Modifications

- A carrier shall neither remove a drug nor increase the cost share for a drug from an approved formulary for an individual or small group health benefit plan unless:
  - The drug is not approved by the FDA;
  - The FDA issues a notice, guidance or warning concerning the safety of the drug; or
  - The drug is approved by the FDA for use without a prescription.
- Individual and small group formularies will be approved and locked down at the same time that the rate and form filings finalized.

Formulary Template

- Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most utilized benefit cost-share design
- Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Benefit Explanation field of the Plans & Benefits Template
- Issuers should place preventive drugs in a separate Zero Cost Share Preventive tier in the Prescription Drug Template

MOOP and Deductible Guidance

- For 2022 individual and small group health benefit plans, the maximum out-of-pocket will be
  - $8,700 single, $17,400 family
- For 2022 HSA plans, the maximum out-of-pocket will be
  - $7,000 single, $14,000 family *(Pending IRS announcement)*
- For 2022 HSA plans, the minimum deductible will be
  - $1,400 single, $2,800 family *(Pending IRS announcement)*

MOOP and Deductible Guidance

- For the 73 percent AV silver plan variations, the maximum out-of-pocket will be
  - $6,950 single, $13,900 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
  - $2,900 single, $5,800 family

Pediatric Dental

- Pediatric dental is not required to be embedded in a medical plan outside the Exchange if the issuer is reasonably assured certified stand-alone coverage has been obtained
- Nevada will consider self-attestation by an applicant to be “reasonable assurance”
- The issuer must obtain “reasonable assurance” that the consumer has certified stand-alone coverage every year at renewal

Benefit Waiting Periods

- Waiting periods are not allowed for essential health benefits
- Carriers can no longer require a waiting period for pediatric orthodontia

SOB: Embedded Pediatric Dental

- Explanations of Type I, Type II, Type III, and Type IV dental services must be included
  - Important services of each category must be listed
  - A detailed list of pediatric dental services must be included in the Evidence of Coverage

SOB: Embedded Pediatric Dental

- The calendar year deductible applicable to pediatric dental services must be prominently displayed on page 1 of the benefit schedule
- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible

Division of Insurance Website

- The Division will not post proposed 2022 rates
- Approved 2022 rates will be posted on October 2nd
- The approved schedule of benefits and evidence of coverage for each individual plan will be posted by November 1st
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template

- Network Adequacy Requirements -

Network Adequacy Regulation

- Applies to individual and small group health benefit plans
- Exemption for a carrier with fewer than 1,000 covered lives in the preceding calendar year or 1,250 lives anticipated in the next year
- Exemption for grandfathered plans

Network Adequacy Submission

- Carriers must submit network plan documentation within plan binders
  - Individual Health Plans – June 2, 2021
  - Small Group Health Plans – July 14, 2021
- Required Documentation
  - CMS ECP/Network Adequacy Template
  - 2022 Nevada Declaration Document
  - Autism Provider Template
  - Network Adequacy Year Over Year Exhibit
  - State Flexibility Grant Narrative

Network Adequacy Timeline

Individual Health Plans

- June 2nd — Deadline for carrier submissions
- August 31st — DOI makes final determinations

Small Group Plans

- July 14th — Deadline for carrier submissions
- October 12th — DOI makes final determinations

Objections/Responses

- The DOI anticipates no more than a two-week turn around after a submission
- Under normal circumstances the carriers will have two weeks to respond to any objections

Network Adequacy Standards

Type	Specialty	Metro		Micro		Rural		CEAC	
		Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	15	10	30	20	40	30	70	60
	Endocrinology	60	40	100	75	110	90	145	130
	Infectious Diseases	60	40	100	75	110	90	145	130
	Psychiatrist	45	30	60	45	75	60	110	100
	Psychologist	45	30	60	45	75	60	110	100
	LCSW	45	30	60	45	75	60	110	100
	Oncology - Medical/Surgical	45	30	60	45	75	60	110	100
	Oncology - Radiation/Radiology	60	40	100	75	110	90	145	130
	Pediatrics	25	15	30	20	40	30	105	90
	Rheumatology	60	40	100	75	110	90	145	130
Facility	Hospitals	45	30	80	60	75	60	110	100
	Outpatient Dialysis	45	30	80	60	90	75	125	110

Essential Community Provider Standards

A carrier must:

- Contract with at least **30%** of available Essential Community Providers (ECP) in each plan's **service area**
- Offer contracts in good faith to all available Indian health care providers in the **service area**
- Offer contracts in good faith to at least one ECP in each category in each **county** in the service area
- Offer contracts in good faith to **all** available ECPs in all counties designated as Counties with Extreme Access Considerations (CEAC) included in the plan's service area

ECP Write-ins

A carrier may write in any provider that submitted a timely ECP petition and:

- Is currently eligible to participate in the 340B Drug Program described in section 340B of the PHS Act; or
- Is a not-for-profit or State-owned provider that would be an entity described in section 340B of the PHS Act but did not receive Federal funding under the relevant section of law referred to in section 340B of the PHS Act
  - Such providers include not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act

Network Adequacy Review Process

- For each specialty and standard, issuer-submitted data will be reviewed to make sure that the plan provides access to at least one provider in each listed provider types for at least 90 percent of the population sample in the service area.
- Justification should describe any established patterns of care and the availability of providers in the specialty type related to the deficiency within the applicable geographic service area
- Access plan should be based upon established patterns of care

Network Adequacy Review Process

Please note the following in preparing the Network Adequacy section:

- In classifying a facility as a hospital consider the definition of hospital under NRS 449.012 as well as the definition provided by the Centers for Medicare and Medicaid Services

  Templates submitted with urgent care facilities classified as hospitals will be objected to and be required to submit a corrected template

- Check data for error
  - Addresses with no city, state, or zip codes
  - Typographical errors in provider names or street addresses
  - Misclassification of a provider specialty or facility specialty

Network Adequacy State Flexibility Grant

Identifying Market Outliers in Network Access for High-Cost Illness

- Using time or distance standards analysis
- The following illnesses will be studied
  - Cancer, diabetes mellitus, epilepsy, heart disease, HIV, multiple sclerosis, rheumatoid arthritis and severe mental illness
- Each disease has been paired to providers based on customary patterns of care
- Outliers will be investigated further to determine if discrimination for a particular disease exists due to network design
- Each carrier will submit a narrative including established patterns of care for treatment; highlighting the accessibility of the providers included in the treatment of these illnesses based on the health plan network used for each plan being offered.

Network Adequacy State Flexibility Grant

Disease	Specialty
Cancer	021 Medical Oncology and Surgical Oncology
	022 Radiation Oncology
	047 Diagnostic Radiology
Diabetes Mellitus	012 Endocrinology
	015 General Surgery
	023 Ophthalmology
	028 Podiatry
Epilepsy	019 Neurology
	047 Diagnostic Radiology
Heart Disease	008 Cardiovascular Disease
	035 Cardiothoracic Surgery
	041 Cardiac Surgery Program
	042 Cardiac Catheterization Services

Disease	Specialty
Hepatitis C	014 Gastroenterology
	015 General Surgery
	017 Infectious Diseases
HIV	017 Infectious Diseases
Multiple Sclerosis	019 Neurology
	049 Physical Therapy
Rheumatoid Arthritis	015 General Surgery
	031 Rheumatology
	049 Physical Therapy
Severe Mental Illness	029 Psychiatry
	040 General Acute Care Hospital
	052 Inpatient Psychiatry
	103 Psychology

- Proposed Legislation- 81st Session - 2021

Health Related Bills

- SB 5 Telehealth
- SB 40 All claims database
- SB 56 Telehealth related to behavioral health dervices
- SB 139 Coverage related to gender dysphoria
- AB 178 Relating to prescription drugs
- AB 181 MHPAEA Reporting and other provisions
- SB 190 Related to administration of contraceptives
- SB 251 Related to genetic counseling and testing
- SB 269 Related to dental plans and overpayment recovery
- SB 290 Related to prescription drugs for the treatment of cancer
- SB 325 Related to prescriptions and testing for HIV
- AB 347 Related to all payor system
- SB 380 Related to prescription reporting
- SB 391 Provisions related to teledenistry

Contact Us

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Questions